Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1 DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TEXAS 75243

Respondent Name

TEXAS SCHOOLS PROPERTY & CASUALTY

Carrier's Austin Representative Box

Box Number 43

MFDR Tracking Number

M4-12-2296-01

MFDR Date Received

March 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...it is our position that JI Specialty Services has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to [injured worker]. Your help in resolving this case is appreciated."

Amount in Dispute: $18,245.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A contested Case Hearing was held on December 29, 2011. The Hearing Officer reached a decision and entered an order. Decision: 'The compensable injury of 12/08/2009 does not extend to and include a 3 mm disc protrusion L5-S1 with a posterior central annulus fibrosis fissure, S1 radiculopathy and mild left L5-@1 foraminal stenosis,. Claimant reached MMI on February 10, 2010. Claimant's impairment rating is 0%.' Order: 'Carrier is not liable for the benefits at issue in this hearing and it is so ordered. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.' In compliance with 134.600(h), the carrier reviewed 2 preauthorization requests based on medical necessity only on 8/30/2011 (10000466) and 10/19/2011 (5019128), and the carrier included the following notice of unresolved disputes to the provider in the preauthorization letters."

Response Submitted by: JI Specialty Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 21, 2011 through December 6, 2011	Chronic Pain Management, medical team conference, office visit, health and behavior assessment, environmental intervention, psychological testing	$18,245.88	$16,344.34

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 amended to be effective May 2, 2006, 31 TexReg 3566, sets out the procedures for preauthorization.

3. 28 Texas Administrative Code §134.204, applies to workers' compensation specific codes, services and programs provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 1, 2011, August 24, 2011, September 19, 2011, September 21, 2011, October 17, 2011, October 25, 2011, October 28, 2011, November 7, 2011, November 8, 2011, November 11, 2011, November 15, 2011, November 18, 2011, November 22, 2011, November 23, 2011, December 1, 2011, December 14, 2011, December 30, 2011, January 6, 2011, January 12, 2012, January 23, 2011, January 31, 2011, February 7, 2011, February 13, 2012,
   - 219 – Based on extent of injury
   - 5053 – Treatment is not related to original work injury
   - 193 – Original payment decision is being maintained. The claim was processed properly the first time

Issues

1. Was the issue of extent of injury resolved prior to the filing of Medical Fee Dispute Resolution?
2. Did the requestor obtain preauthorization for the chronic pain management program?
3. Did the requestor submit documentation to support that the services rendered were billed?
4. Did the requestor submit documentation to support fair and reasonable reimbursement for CPT codes 90882 and 99367?
5. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307 the MDR request may be submitted if the dispute does not contain issues of compensability, extent of injury or liability (CEL). Review of the medial bills finds that the requestor billed with diagnosis code 847.2 *Sprain Lumbar Region*. The requestor included a copy of a CCHI decision signed by the hearing officer on January 2, 2012 which states, in pertinent part that "…the claimants compensable injury is a lumbar strain-sprain…" Therefore, the CEL issues were resolved prior to the filing of the MDR request. MDR has jurisdiction to review the disputed issues.
2. Per 28 Texas Administrative Code §134.600 (p)(10) "(p) Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation." Review of the preauthorization letter (#10000466) dated August 30, 2011 authorizes chronic pain management program, 10 visits to be completed within 60 days for the date of authorization. The requestor obtained a second preauthorization (#5019128) on October 19, 2011, authorizing 10 visits (80 hours) to be completed within 60 days from date of authorization.
3. Review of the submitted documentation finds that the requestor billed for 10 sessions of chronic pain management from September 19, 2011 to October 17, 2011, under preauthorization # 10000466. Review of the submitted documentation finds that the requestor billed for 10 sessions of chronic pain management from November 16, 2011 to December 6, 2011 under preauthorization #5019128. The requestor submitted documentation to support the number of hours billed for the chronic pain management sessions in dispute.
4. Per 28 Texas Administrative Code §134.204(h)(A) "If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."
5. Per 28 Texas Administrative Code §134.204(h)(5) "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier. B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes." Review of the submitted documentation finds that:
   - September 19, 2011, CPT 97799-CP-CA, 7 hours x $125.00/hour. Recommend payment $875.00.
   - September 20, 2011, CPT 97799-CP-CA, 8 hours x $125.00/hour. Recommend payment $1,000.00.
   - September 21, 2011, CPT 97799-CP-CA, 8 hours x $125.00/hour. Recommend payment $1,000.00.
   - September 22, 2011, CPT 97799-CP-CA, 6.5 hours x $125.00/hour. Recommend payment $812.50.
   - October 3, 2011, CPT 97799-CP-CA, 6.5 hours x $125.00/hour. Recommend payment $812.50.
   - October 5, 2011, CPT 97799-CP-CA, 4.5 hours x $125.00/hour. Recommend payment $562.50.
   - October 7, 2011, CPT 97799-CP-CA, 7 hours x $125.00/hour. Recommend payment $875.00.
   - October 10, 2011, CPT 97799-CP-CA, 7 hours x $125.00/hour. Recommend payment $875.00.

- October 14, 2011, CPT 97799-CP-CA, 6.75 hours x $125.00/hour. Recommend payment $843.75.
- October17, 2011, CPT 97799-CP-CA, 7 hours x $125.00/hour. Recommend payment $875.00.
- November 16, 2011, CPT 97799-CP-CA, 6.5 hours x $125.00/hour. Recommend payment $812.50.
- November 17, 2011, CPT 97799-CP-CA, 6.75 hours x $125.00/hour. Recommend payment $843.75.
- November 21, 2011, CPT 97799-CP-CA, 7 hours x $125.00/hour. Recommend payment $875.00.
- November 22, 2011, CPT 97799-CP-CA, 7 hours x $125.00/hour. Recommend payment $875.00.
- November 23, 2011, CPT 97799-CP-CA, 7 hours x $125.00/hour. Recommend payment $875.00.
- November 28, 2011, CPT 97799-CP-CA, 5 hours x $125.00/hour. Recommend payment $625.00.
- November 29, 2011, CPT 97799-CP-CA, 7 hours x $125.00/hour. Recommend payment $875.00.
- December 1, 2011, CPT 97799-CP-CA, 7 hours x $125.00/hour. Recommend payment $875.00.
- December 2, 2011, CPT 97799-CP-CA, 7 hours x $125.00/hour. Recommend payment $875.00.

6. Per 28 Texas Administrative Code §13.203(b)(1) "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." Review of the submitted documentation finds that:
   - June 21, 2011, CPT code 99203: The requestor submitted documentation to support that the services rendered were billed. The MAR amount is $165.80, the requestor requested $150.00, therefore this amount is recommended.
   - June 21, 2011, CPT code 96151 x 4 units: The requestor submitted documentation to support that the services rendered were billed, therefore reimbursement is recommended in the amount of $131.84.
   - July 29, 2011, CPT code 96101: The reimbursement for this code is per hour, review of the submitted documentation finds that the requestor did not document the 3 hours billed on the CMS-1500. Reimbursement cannot be recommended for the disputed charge.
7. Per 28 Texas Administrative Code §134.203(f) "(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)." The CPT codes 99367 and 90882 do not have an assigned reimbursement by Medicare and are therefore subject to fair and reasonable reimbursement in accordance with §134.1.
8. Per 28 Texas Administrative Code §133.307(c)(2)(O) "(2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include. O) documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that:
   - The requestor did not provide documentation to demonstrate how it determined it's usual and customary charges for CPT code 99367 and 90882.
   - Documentation of the comparison of charges to other carriers was not presented for review.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended for CPT codes 99367 and 90882.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $16,344.34.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $16,344.34 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 22, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.